

The Ryan White HIV/AIDS Treatment Program (formerly the Comprehensive AIDS Resources Emergency Act) was first enacted into law in 1990, and amended in 1996, 2000, and 2006. The 2006 amendments, referred to as the Ryan White HIV/AIDS Treatment Modernization Act of 2006 [1], established new criteria for eligibility determination for eligible metropolitan areas (EMA) and emerging communities (EC), and introduced a new funding category under Part A (formerly Title I) of the law. The new category of grantees is termed transitional grant areas (TGA). The 2006 amendments also changed the data requirements used for the formula award allocations.

In FY2009, the Health Resources and Services Administration (HRSA), for the third year in a row, used total counts of living cases of HIV and living cases of AIDS in the Ryan White HIV/AIDS Treatment Program Parts A and B (formerly Titles I and II) allocation formulae. Prior to FY2007, only AIDS cases, adjusted by a survival rate (estimated living AIDS cases), were used in the formulae. Beginning in FY2007, persons living with HIV (non-AIDS) as well as persons living with AIDS, as reported to and confirmed by the Director of the Centers for Disease Control and Prevention (CDC), are used to calculate funding allocation amounts. See Technical Notes for further explanation.

As instructed by the law, HRSA continues to use cumulative cases of AIDS reported to and confirmed by the Director of CDC for the most recent 5 calendar years to determine eligibility for Part A grantees. Part A has two categories of grantees, EMAs and TGAs. EMAs are defined as jurisdictions with more than 2,000 AIDS cases reported to and confirmed by the Director of CDC over the most recent 5 calendar years and with a minimum population of 50,000 persons. (Prior to FY2007, the minimum population threshold for inclusion as an EMA was 500,000.) An area will continue to be an EMA unless it fails to meet both of the following requirements for 3 consecutive fiscal years: a) A cumulative total of 2,000 or more cases of AIDS reported during the most recent period of 5 calendar years, and b) A cumulative total of 3,000 or more living cases of AIDS as of December 31 for the most recent calendar year for which such data are

available. Note: The first year the consecutive year requirement was applied was FY2008. Areas that have fallen below the required EMA thresholds that continue to be eligible are presented in the tables and remain designated as EMAs. There are 24 EMAs for FY2009, including the two new EMAs (Nassau-Suffolk, NY and New Haven-Bridgeport-Danbury-Waterbury, CT) that were previously classified as TGAs for FY2007 and FY2008. These two new EMAs were reclassified as EMAs for FY2009 as a result of a decision on April 25, 2008 by the United States Court of Appeals for the Second Circuit, in the matter of *County of Nassau, New York, et al, v. Michael O. Leavitt, Secretary of the U.S. Department of Health and Human Services, et al.*

The other category of Part A grantees, TGAs, are defined as those jurisdictions with at least 1,000 but fewer than 2,000 AIDS cases reported to and confirmed by the Director of CDC over the most recent 5 calendar years and with a minimum population of 50,000 persons. An area will remain a TGA unless it fails to meet both of the following requirements for 3 consecutive fiscal years: a) A cumulative total of at least 1,000—but fewer than 2,000—cases of AIDS reported during the most recent period of 5 calendar years, and b) A cumulative total of 1,500 or more living cases of AIDS as of December 31 for the most recent calendar year for which such data are available. Note: The first year the consecutive year requirement was applied was FY2008. Areas that have fallen below the required TGA thresholds that continue to be eligible are presented in the tables and remain designated as TGAs.

For FY2009, there were 32 TGAs, including the 5 new TGAs that started receiving Part A funding for the first time in FY2007 (these 5 were ECs in FY2006). The 5 new TGAs added in FY2007 were: Baton Rouge, LA; Charlotte-Gastonia-Concord, NC-SC; Indianapolis, IN; Memphis, TN-MS-AR; and Nashville-Davidson-Murfreesboro, TN. No new TGAs were added in FY2009.

The geographic boundaries for all jurisdictions that received Part A funding in FY2009—both EMAs and TGAs—are those boundaries that were in effect when they were initially funded under Part A (formerly

Title D). For all newly eligible areas, the boundaries are based on current metropolitan statistical area (MSA) boundary definitions determined by the Office of Management and Budget for use in federal statistical activities [2].

The Part B EC eligibility is also determined based on the number of living AIDS cases in that jurisdiction. ECs are defined as metropolitan areas for which there have been at least 500 but fewer than 1,000 AIDS cases reported to and confirmed by the Director of CDC over the most recent 5 calendar years. An area will remain an EC unless it fails to meet both of the following requirements for 3 consecutive fiscal years: a) A cumulative total of at least 500—but fewer than 1,000—cases of AIDS reported during the most recent period of 5 calendar years, and b) A cumulative total of 750 or more living cases of AIDS as of December 31 for the most recent year for which such data are available. A hold harmless provision was added for ECs, so that all ECs that were eligible for funding in FY2007 and in FY2008 remained eligible for funding in FY2009, even if they no longer met the eligibility requirement.

The number of persons living with HIV and the number of persons living with AIDS are used to determine funding levels for Ryan White Parts A and B. For FY2009, CDC provided HRSA with data files containing the total number of persons reported living with AIDS through calendar year 2007 for all jurisdictions as well as the total number of persons living with HIV for all jurisdictions with name-based HIV reporting. Jurisdictions that did not yet have mature name-based HIV reporting sent tables containing the total number of code-based reported persons living with HIV directly to HRSA; those areas are listed in the Technical Notes.

Under the 2006 reauthorization, HRSA was required to accept code-based or non-name HIV data when calculating funding amounts. In response, HRSA, in consultation with the CDC, developed “Technical Guidance for Submission of HIV non-AIDS Data Under the Ryan White HIV/AIDS Treatment Modernization Act of 2006” to ensure that the data reported to HRSA by code-based areas followed a uniform process similar to the process used to report name-based data to the CDC. Data submitted directly to HRSA were required to be certified by the State Epidemiologist. The Technical Guidance also allowed the State Epidemiologist in areas with operational name-

based reporting systems established prior to December 31, 2006 to request that CDC report their HIV non-AIDS data to HRSA. The State Epidemiologist was required to make such requests in writing to both HRSA and CDC. As required by the 2006 legislation, HRSA reduced the total number of code-based reported persons living with HIV by 5 percent for those areas that reported their code-based data directly to HRSA. The code-based HIV cases were then added to the number of persons living with HIV and the number of persons living with AIDS reported to HRSA from CDC. For EMAs/TGAs that cross state lines, it was possible to have HIV cases reported by CDC from the name-based reporting state(s) as well as HIV cases reported directly to HRSA from the code-based reporting state(s). The following areas had both name-based and code-based HIV cases included in their total cases for FY2009: Boston, MA-NH; Portland-Vancouver, OR-WA; St. Louis, MO-IL; and Washington, DC-MD-VA-WV. The 5-percent reduction rule was only applied to the HIV cases reported to HRSA directly from the code-based state(s). The number of persons living with HIV and the number of persons living with AIDS were then added together to arrive at the total number of living cases of HIV and AIDS for each EMA, TGA, EC, state, and territory. These totals were used in the Part A and B funding formula calculations.

References

1. Health Resources and Services Administration. The Ryan White HIV/AIDS Treatment Modernization Act of 2006. Public Law 109-45. Available at: <http://hab.hrsa.gov/law/reauth06.htm>. Accessed August 27, 2010.
2. Office of Management and Budget. Standard for defining metropolitan and micropolitan statistical areas. *Federal Register* 2000;65:82228–82238. Also available at: <http://www.whitehouse.gov/omb/fedreg/metroareas122700.pdf>. Accessed August 27, 2010.